EXHIBIT B

2	Coinsurance Amount
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
M127	Missing patient medical record for this service.
N130	Alert: Consult plan benefit documents for information about restrictions for this service.
N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or an Unlisted procedure.

[redacted]

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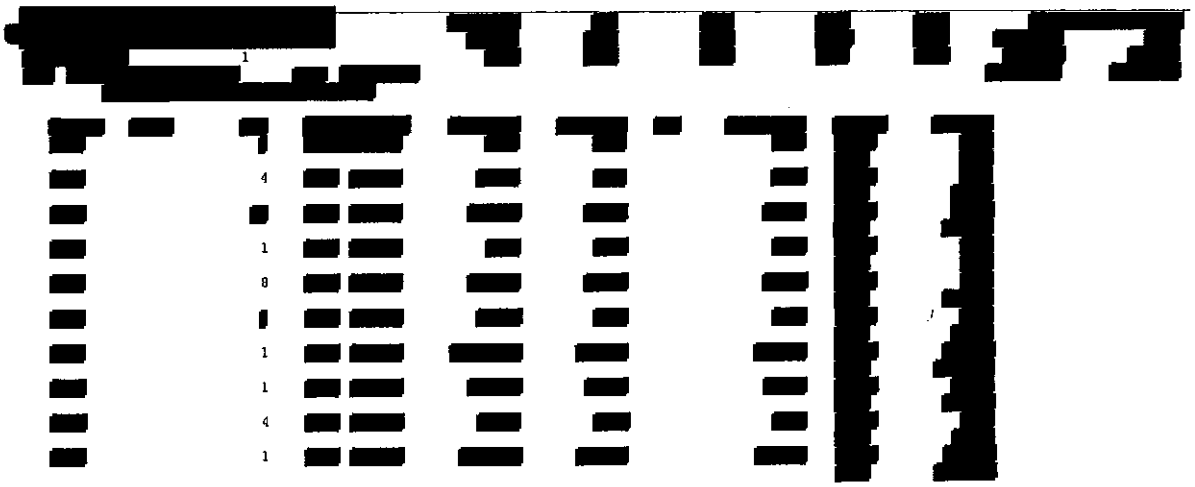
Patient / PCN Number / Policy Number	BillType / Clm St	From Date / Thru Date / Pat Stat	Covd / NCovd / Cost	Rptd Chrgs / Ncovd Chrgs / Denied Chrgs	DRG Nbr / DRG Amt / Blood Ded	Prof Comp / Outlier / Deductible	CoIns / MSP Liable / Reimb Rate	MSP Pri / Per Diem / ESRD Amt	HCPCS Amt / Cont Adj / Cov Chrgs	Interest / Pat Refund / Net Reimb
[redacted]				1169412.20	460	0.00	0.00	0.00	0.00	0.00
				0.00	0.00	0.00	0.00	0.00	1150138.80	0.00
	1			0.00	0.00	0.00	0.00	0.00	19273.37	19273.37
ICN: [redacted]		MRN: 000005271							PAT RESP:	1150138.83

Claim Level Adjustments: CO45 1150138.8

Claim Level Remark Codes: N350

Rev Cd	HCPCS	Qty	Service Date	Chrg Amt	Pymt Amt	APC	Allow Amt	Adj Cd	Adj Amt
[redacted]									
		1							
		1							
		2							
		1							
		1							
		1							
		1							
		8							
		1							
[redacted]									
		1							
		1							



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Check Summary :

Check Number :	[redacted]	Check Total :	33178.85	Claim Count :	6
Covered Chrg :	34727.17	Contract Chrg:	1217378.74	Provider Pay :	33178.85
NonCov Chrg :	1321.39	Denied Chrg :	0.00	Deductibles :	0.00
CoInsurance :	226.93	Outlier Chrg :	0.00	Pat Refund :	0.00
Interest :	0.00	MSP Primary :	0.00	MSP Liability:	0.00

Provider Level Benefits :

Reported Check Amount :	33178.85
Total Claim Payments :	33178.85
Total PLB Adjustments :	0.00
Sum Payment - Adjust :	33178.85

GLOSSARY: REMARK AND REASON CODES

104 Managed care withholding.

2 Coinsurance Amount

45 Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

N350 Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or an Unlisted procedure.